Division of Public and Behavioral Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING NVS4937AGZ 11/14/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4240 AL CARRISON AS TIME GOES BY 7** LAS VEGAS, NV 89129 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Y 000 Initial Comments Y 000 This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 11/14/14. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Division of Public and Behavioral Health. The facility is licensed for ten Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was ten. Ten resident files were reviewed and eight employee files were reviewed. The facility received a grade of A. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified: Y 626 449.2702(6)(b)(1,2,&3) Restraint Definition Y 626 SS=E NAC 449.2702 Written policy on admissions; eliaibility for residency. As used in this section: (b) "Restraint" means: (1) A psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms: (2) A manual method for restricting a If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

STATE FORM

Z5CU11

DEC 04 2014

BUREAU OF HEALTHCARE QUALITY & COMPLIANCE LAS VEGAS, NV

Division of Public and Behavioral Health

12/5/14 Acceptable POC - P. Elkino, NU

PRINTED: 11/17/2014 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING:

H19 (X3) DATE SURVEY COMPLETED

NVS4937AGZ

B. WING

11/14/2014

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AS TIME GOES BY 7 4240 AL CARRISON LAS VEGAS, NV 89129				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(X5) DMPLET DATE
Y 626	Continued From page 1	Y 626		
	resident's freedom of movement or his normal access to his body; or (3) A device or material or equipment which i attached to or adjacent to a resident's body that cannot be removed easily by the resident and restricts the resident's freedom of movement or his normal access to his body.		DONT USE FULL BED RAILS 2 WILL NOT USE FULL BED - RAILS OR BLOCK BED -	
	This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure 3 of 10 resident beds were free from restraints. (Resident #1, #2 and #3)		USING CHAIR AND WHEEL - CHAIR (3) CHECKING THAT THEY DON'T	
	Findings include:	Î	USE FULL REPRAILS AND	
	On 11/14/14 at 2:30 PM, Resident #1's bed was observed to have full-side bed rails attached.		BLOCKING THE BED WITH CHAIR OR WHEELCHAIR	
	On 11/14/14 at 3:00 PM, the caregiver (Caregive #1) and the administrator acknowledged the bed had full -side bed rails attached.	r	(4) CAREGIVER / ADMINISTRATOR	
	On 11/14/14 at 2:30 PM, Resident #2's bed was observed to have full-side bed rails attached.		5 HOVEMBER 20, 2014	
	On 11/14/14 at 3:00 PM, Caregiver #1 and the administrator acknowledged the bed had full-side bed rails attached.			
	On 11/14/14 at 2:30 PM, Resident #3 was observed in a bed with the right side of the bed bushed up against the wall. The left side of the bed had half-side bed rails in an up position, a wheelchair and a recliner pushed up against the bed.			
	On 11/14/14 at 3:00 PM, Caregiver #1 and the administrator acknowledged the wheelchair and the recliner were pushed up against the left side are cited, an approved plan of correction must be returned with the cited.			

PRINTED: 11/17/2014 Division of Public and Behavioral Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING ___ NVS4937AGZ 11/14/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4240 AL CARRISON AS TIME GOES BY 7** LAS VEGAS, NV 89129 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Y 626 | Continued From page 2 Y 626 of the bed. Severity: 2 Scope: 2

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM